

**BOARD OF REGISTERED NURSING**

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Ruth Ann Terry, MPH, RN
Executive Officer

NURSING PRACTICE COMMITTEE
MEETING MINUTES

DATE: January 11, 2007

TIME: 2:00 pm – 3:00 pm

LOCATION: Burbank Airport Marriott Hotel & Convention Center
2500 Hollywood Way
Burbank, CA 91515

COMMITTEE MEMBERS

PRESENT: Susanne J. Phillips, RN, MSN, APRN-BC, FNP, Chair
Grace Corse, RN
Carmen Morales, RNC, MSN, FNPC
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT: Janette Wackerly, MBA, RN, NEC Liaison
Louise Bailey MEd, RN, SNEC
Miyo Minato, MN, RN, NEC
Ruth Ann Terry, Executive Officer, BRN
Heidi Goodman, Assistant Executive Officer, BRN
Grace Arndt, MSN, RN, NEC
Carol Bell, MA, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN, NEC
Carol Mackay, MSN, RN
Alice Takahashi, MSN, RN, NEC
LaFrancine Tate, Board President
Nancy Beecham, Board Member
Donna Fox, RN, Regulatory Policy Specialist, CA Nurses Assoc
Monica Weisbrich, RN ANA/C Board
Tricia Hunter, ANA/C
Carol Stanford, Manager, BRN

Susanne J. Phillips, Chair, opened the meeting at 2:00 pm with introduction of the committee members.

1.0 Approve/Not Approve: Minutes of October 19, 2006

MSC: Corse/Dietz approved Minutes of October 19, 2006.

2.0 Presentation by: Suzanne Graham RN, PhD
Director of Patient Safety -California Region
Kaiser Permanente

Topic: Responsible Reporting and Accountability in a “Just Culture”. Dr Lucian Leape, Professor of Public Health, Harvard School of Public Health, testimony before Congress on Health Care Quality Improvement stated the single greatest impediment to error prevention in the medical industry is “that we punish people who make errors”.

When an error takes place in healthcare, leaders and managers must make a decision on how to handle the error –should discipline take place? Should the situation be utilized as a learning activity? Should the situation be ignored because the error did not cause harm to the patient? Should the person be terminated immediately because the patient was harmed?

The Kaiser Policy and Procedure on Responsible Reporting and Accountability notes the following: It is the policy of Kaiser Permanente, Northern California that leadership and management are responsible for creating and sustaining an environment in which staff and physicians are able to report without fear of punishment. When medical error, adverse events, and or near miss occur, it is the responsibility of physicians and staff to report the event through established mechanisms. It is also the responsibility of leaders, physicians, and staff to take action to address the root cause and prevent the mistake or unintended failure from happening again. “Exception: Punitive discipline is indicated when the employee is under the influence of drugs or alcohol: has deliberately violated rules or regulations; specifically intended to cause harm: or engaged in egregious negligence”.

The MS. Graham’s presentation included the following objectives:

- (1) To define a culture of patient safety
- (2) To identify reasons why people make errors
- (3) To recognize the importance of reporting errors that cause harm; errors that do not cause harm; and near misses
- (5) To discuss the elements of a “just culture”

The individual committee members commented on the value of the organization having a specific plan for addressing errors and events that recognize the human aspects of the caregiver not intentionally causing harm. Discussion of “drift or

drifting” from established policy and procedure that lends to practice changes. The committee chair stated the plan would be to continue the dialogue about safety issues.

3.0 Open Forum - No public input

The meeting was adjourned at 2:30 pm.

Submitted by:

Janette Wackerly, MBA, RN

Approved by:

Susanne J. Phillips, RN - Chair